Referral to a specialist clinic may carry a particularly heavy stigma.

Distance and travel. Cumbria is a rural area with a low population density (72 per km^2); therefore patients have to travel very considerable distances in order to attend a clinic.Many patients rely on limited public transport services and travelling difficulties may be compounded by restricted clinic opening times. Public transport is also expensive and potential new patients will be unaware that they may be entitled to reclaim their transport costs. A busy city clinic enjoys the advantages of being open on a "full-time" basis. Some clinical specimens will need to be sent to central laboratories, often located in other districts, and this introduces delays and procedural complications.

Social and sexual characteristics. Rural populations may have different priorities in life from city dwellers, and may place a low importance on those aspects of health care which they perceive as being trivial. Young people have a degree of privacy which would not be available in a city. The tourist industry attracts many young seasonal workers and provides a constant stream of new sexual partners (although many rural people do not wish to become involved with outsiders). Sexually transmitted diseases (STD) are known to be common in the tourist industry.

Confidentiality is more difficult to maintain in a small town than in a city. Any patient attending a hospital is likely to be recognised and questioned about the reason for their attendance. Some patients travel considerable distances in order to attend a clinic at which they believe they would be unrecognised.

Medical lifestyle. The rural doctor may own a substantial property, breathe clean air, live in tranquility, and be able to enjoy rural pursuits. Attending regional or national meetings may pose problems; even an audit meeting with one's nearest professional neighbour can involve a long journey. Taking annual or study leave is difficult; the consultant will not have the benefit of junior staff, and may have only occassional support from clinical assistants. Some consultant colleagues may recognise the need for a GUM service and be very supportive; others may not understand the role of this speciality. Although much time will be spent travelling by car, time spent in one's own car may be more congenial than travel by London Underground! It is difficult to undertake the care of sick inpatients when duties are split between several widely separated sites.

Management of patients. Treatment and follow-up regimes need to be kept simple to involve the minimum number of attendances, otherwise the default rate will be excessively high. Epidemiological treatment may be appropriate more frequently than in a city clinic.

In some city clinics, genital warts are treated by a different doctor or nurse at each visit, and multiple attendances are not unusual. Rural consultants who regularly review their patients will recognise the need for careful evaluation and treatment of warts at each visit.

The ideal treatment for gonorrhoea, in a patient who cannot be depended upon to reattend would be effective against both penicillin sensitive and resistant strains, would eliminate infection from all genital and extragenital sites, and would treat concurrent chlamydial infection. There is no such treatment, but it may be advantageous to treat patients with gonorrhoea for possible concurrent chlamydial infection. Purists may raise several objections; what should be written on the contact slip, what is the appropriate KC60 diagnosis, how can the overtreatment of some patients be justified? Despite these objections, concurrent anti-chlamydial treatment for patients with gonorrhoea is now considered by some authorities to be an important component of programs to control chlamydial infection.[2]

Repeated serological tests for syphilis could be restricted to certain patient groups, such as those with genital ulcers or with known higher risk exposures.

Contact tracing. STDs are endemic in cities but present as sporadic cases or clusters in rural areas. The value of contact tracing an index case is therefore enhanced. Indeed, effective contact tracing over a period of time could lead to a high degree of control over certain conditions. However, geographical and social factors make contact tracing difficult, and migrant workers and holiday-makers may constantly introduce new infections. Contact tracing patients infected with human immunodeficiency virus (HIV) raises many important issues.[3] In rural areas with a low prevalence of HIV, the benefits of contact tracing are very clear, but the problems of maintaining confidentiality are also magnified.

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BOOK REVIEWS

A Colour Atlas of Dermato-immunohistocytology. By Hiroaki Ueki and Hideo Yaoita. (£60.00.) London: Wolfe Medical, 1989.

In recent years there have been major advances in the understanding of the immunology and the immunophysiology of the skin and its function. The identification of various new antigenic structures on different types of cells and tissues, the development of monoclonal antibodies and advances in the use of various labels in detecting these cell markers has greatly helped with the diagnoses of many cutaneous disorders and has given us a better understanding of the pathogenesis of these disorders. Professors Ueki and Yaoita have produced a beautiful volume which illustrates the state of

the art in immunohistocytological techniques.

With approximately 100 contributors there is understandably some slight unevenness particularly in the sections on individual diseases. For instance the section on Tsutsugamushi disease is twice as long as the section on common naevi. One of the best chapters is in fact the introductory chapter on technical procedures in immunohistocytology. Many of the technical problems are highlighted and there are clear diagrams illustrating the basics of the different techniques. The book however does not attempt to be a practical manual for doctors or laboratory workers. The first chapter is well referenced, the references to the other chapters being variable. One of the strongest features of this book is the quality of the illustrations. Both the photomicrographs and diagrams are of superb quality and illustrate what excellent results can be achieved in the right hands. One just wonders how many procedures were carried out to enable this number of quality illustrations to be included in one volume!

A Colour Atlas of Dermatoimmunohistocytology can be warmly recommended to anyone interested in the many new and valuable laboratory techniques which are currently being applied to the diagnosis of skin disorders. I am sure every department carrying out such studies will wish to buy a copy. Whether individual workers will wish to buy their own personal copy I think is more doubtful.

NEIL P SMITH

My life before penicillin. By SM Laird. Brauton, Devon. Merlin Books, 1988, (pp 491, illus) £14.95.

Following the February 1955 meeting of our V.D. Society the author and I were given a lift to Euston station by Dr R R (Dick) Willcox. The conversation focused on the contents of the next issue of the Society's journal. Dr Sydney Laird, in the fourth of his 15 years as editor was giving nothing away. Ever enthusiastic to be in the van, Dick pressed for an informative forecast. Sydney countered with a reader-friendly version of an editor's right to protect his sources. The verbal sparring was worthy of a C P Snow novel. With Euston in sight, Sydney relented. "We don't all have to go as far as East Africa to make a novel observation on treponematoses", a reference to Dick's discovery of njovera (*Lancet*, 1951;i:558–60). This riposte was delivered with a puckish, teasing friendliness which ensured its acceptance. Dick's curiosity was to be satisfied only after another two weeks when he read Sydney's "Yaws in Manchester" (*Br J Venereal Dis* 1955;**31**:30–32).

This vignette gives some idea of the man who has favoured us with the first half of his autobiography. It is a rare treat.

With increasing blindness the author taught himself to type and this book is a product of his new-found skill.

Dr Laird was born and bred in Kilmacolm on the southern shores of the Clyde estuary. He was the youngest of three sons of a country GP. He coped with the death of his mother during his teens, the resultant maledominated household, and more than a decade of travelling daily by train to school, University and hospitals in the gloomy Glasgow of the Great Depression. Sport helped to sustain him, firstly running, and then tennis. His passion for rugby has been life-long, as have been some of his student friendships. He qualified in 1934.

All but one of his housemanships were in Liverpool hospitals. He pursued experience and learning with the "work ethic" application common to many Scots of his time. Some measure of this comes with his first year in a non-resident post in venereology in Liverpool. During that time he acquired an MD, and a DPH and the Fellowship of the Glasgow College of Physicians and Surgeons.

Most of his six years in the wartime Royal Army Medical Corps were devoted to his chosen speciality. He distinguished himself while Western Command Venereologist by his detailed research and discovery of syringe-transmitted jaundice. Within a few years the condition was recognised world-wide and prevented.

In the midst of all this he found time to embark on a happy marriage, found a family and find satisfaction in wide reading with biography and the precision of the law amongst his favourites.

As might be expected from an ex-editor the writing flows smoothly and with a clarity of crystal quality. It is a joy to read. Where drama appears it is studiously controlled; masterly understatements are tersely delivered and the wit has a sharp, easy and graceful quality that gives real pleasure.

Sydney Laird of course was only one of many Scots who took the road to England during the hundred years from the mid-19th century. His story will be essential reading for future historians comparing the contributions of such immigrants with those arriving later from the Commonwealth and the new ones now beginning to appear from Europe. Scots of Sydney Laird's calibre will be hard to beat.

When men like Dick Willcox and Sydney Laird were at the height of their chosen speciality, a venereologist was jokingly defined as a person with many acquaintances but few friends. I would venture to suggest that the reason you haven't heard this before is due to Dr Laird. My abiding memory of this book will be his capacity for friendships. This gift fitted him uniquely for his speciality. His patients must have been well served. By reading this book you will share their great good fortune.

RS MORTON

Urinary Tract infection and inflammation by Jackson E Fowler with contributions by Mary Lee and Anthony A Caldamone. (Pp 339, £55.50 hardback). Chicago. Year Book Medical Publishers Inc 1989 (ISBN 0-8151-3265-4).

My heart sank when I read the introduction to this book. It was vague and verbose and as I was unable to "slot-in" to the author's conceptual framework I initially understood little of it. This is a shame as it rather coloured my impression of the rest of the book, so my advice to potential readers is to leave it out.

This initial hurdle overcome, the style of the book becomes more pleasing and the content more informative with each succeeding chapter. The first three chapters provide a non-clinical overview of the subject, with a chapter on anatomy followed by chapters on antimicrobial agents and bac-